Chapter 12
Creating Optimal Clinical Workplaces by Transforming Leadership and Empowering Clinicians

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> If doing things that produce healthier work environments pay off for both employees and employers, why don't more companies do it? Jeffrey Pfeffer, Dying for a Paycheck

Clinicians are not faring well in the current health care environment. Physician burnout has been recognized as a public health emergency, in the United States, with prevalence rates running about 50% (Massachusetts Medical Society, Massachusetts Health and Hospital Association, Harvard T.H. Chan School of Public Health, & Harvard Global Health Institute, 2019; Shanafelt, West, et al., 2019).Other health care professionals are also suffering high rates of burnout. Studies of nurse burnout show a prevalence of 34–86% (McHugh, Kutney-Lee, Cimiotti, Sloane, & Aiken, 2011; Mealer, Burnham, Goode, Rothbaum, & Moss, 2009) and turnover among nurses is especially high. Almost 1 in 5 registered nurses leaves their first job within the first year after completion of training; one third leave within 3 years (Kovner, Brewer, Fatehi, & Jun, 2014). Health care leaders are not immune. A recent poll found that 73% of administrators felt some degree of burnout from their jobs (Medical Group Management Association, 2018). Given the nature of the healing interaction between patient and clinician, burnout among doctors and nurses adversely affects patients as well (National Academies of Science, Engineering, and Medicine, 2019; Panagioti et al., 2018; Windover et al., 2018).

Research has demonstrated that professional burnout arises from a problematic work environment rather than an increased susceptibility among individual workers (Maslach & Leiter, 2016). In health care, clinician burnout results when highly motivated clinicians work in chaotic work environments that are rife with barriers

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that prevent them from engaging in meaningful relationships with their patients—the very reason many choose the profession in the first place. In such work environments, clinicians cannot be successful at their work without constant vigilance and use of multiple workarounds to deal with dysfunctional processes.

Most leaders of health care provider organizations are unsure how to address clinician burnout. Many presume the solution requires reducing clinician workloads or adding wellness programs. Reducing workloads would likely result in lower revenues in the private sector and reduce patient access to needed care, resulting in longer waits for clinical services in both the private and public sectors. Adding wellness programs would result in higher expenses. Few health care systems can financially absorb the resulting negative financial impact to their already narrow operating margins.

We believe the alternative, reducing burnout while improving financial performance along with quality and service metrics, is not only possible, but when realized, provides a health care organization with a significant strategic advantage. Organizations can create optimal clinical workplaces while simultaneously achieving their strategic goals by adopting a leadership style based on coaching rather than top-down mandate and implementing a daily management system that empowers clinicians to fix the problems they encounter while aligning clinicians' efforts with organizational goals (Peikes et al., 2019).

Such transformations require leaders to commit to learning and implementing a new approach focused on organizational health. This chapter will describe these transformations and provide examples of organizations that have successfully created healthier clinical workplaces.

It is worth noting that little published research exists on interventions changing the management system or redesigning workflows to reduce administrative burden in health care (DeChant et al., 2019). This is a critically important area for additional study.

12.1 The Problem of Burnout

Some clinician advocates object to the use of the term *burnout*, because it connotes a problem that is a result of individual weakness and suggests that solutions to increase individuals' resilience to workplace stress are sufficient to address the issue (Rowe, Stewart, Farley, & Marchalik, 2019). Terminology arguments notwithstanding, professional burnout, which was first defined in the 1970s, is "a psychological syndrome in response to chronic interpersonal stressors on the job" (Maslach & Leiter, 2016). It is not simply fatigue or lack of time off; and it is not synonymous with depression. Professional burnout includes three components, which manifest in clinicians as: emotional exhaustion ("I've given all I can and have nothing left to give"), depersonalization or cynicism (a self-protective distancing of oneself from administration or patients when one feels as though one has nothing left to give), and

perceived lack of self-efficacy (feeling as though one is not making a real difference.)

In 2019, the World Health Organization identified burnout as a diagnosis for the first time, defining it in the ICD-11 as a "workplace phenomenon...resulting from chronic workplace stress that has not been successfully managed" (World Health Organization, 2019). This inclusion may "legitimize" the condition, yet the vague definition represents a missed opportunity to name the cause of the mismanaged stress, namely the workplace and larger organization.

Toxic clinical workplaces and the resultant high rates of burnout among clinicians have a number of potential negative downstream effects.

- Burnout is associated with higher reported intent to a leave current position (Meeusen, Van Dam, Brown-Mahoney, Van Zundert, & Knape, 2011)
- Injury rates among hospital workers are higher than other professions (Occupational Health and Safety Administration, 2013)
- Disruptions in care continuity (Agency for Healthcare Research and Quality, 2017)
- Medical errors, reduced quality of care, lower patient satisfaction (Hamidi et al., 2018; Panagioti et al., 2018; Wallace, Lemaire, & Ghali, 2009; West, Dyrbye, & Shanafelt, 2018)
- Reduced revenues due to physicians restricting clinical hours (Shanafelt et al., 2016)
- Burnout in physicians is associated with substance abuse (Jackson, Shanafelt, Hasan, Satele, & Dyrbye, 2016; Oreskovich et al., 2015) and suicide ideation (Shanafelt et al., 2011); the rate of suicide among physicians is much higher than that of the general population: 40% greater in male physicians and 130% greater in female physicians (Schernhammer, 2005).

These downstream effects result in negative consequences for patients, health care professionals, health care organizations, and society as a whole.

12.2 The Underlying Causes of the Toxic Clinical Workplace

Maslach and Leiter described six underlying drivers of professional burnout (Maslach & Leiter, 2016). These describe the origins of the toxic clinical workplace, although the degree to which each element impacts a specific workplace varies by organization and by clinical unit.

The six drivers of burnout include:

12.2.1 Work Overload

Work overload is simply too many tasks to complete in a set amount of time. Time pressure and chaotic work environments exacerbate the already high workload in health care. There is increasing information overload as well (Kolusu, 2015). Medical knowledge has grown at an exponential rate; it is estimated to *double* in volume every 73 days (Densen, 2011).

12.2.2 Lack of Control

Control is an aspect of autonomy, which is a deeply held value for physicians. In fact, it is one of the intangible rewards physicians seek in pursuing the profession. Several factors have led to a substantial reduction in control in the clinical workplace, especially for physicians. These factors include the increasing corporatization of medicine and physicians moving from private practice to employment, with a significant rise in non-clinician administrators, increased demands on clinicians to achieve outcome metrics, and the imposition of clinical protocols with limited input from clinicians. Prior authorization is another example of lack of control, in that the physician has made a clinical decision that is often then questioned by a non-clinician administrator at an insurance company. Physicians interpret this as a lack of trust of physicians' professional judgement.

12.2.3 Insufficient Reward

In general, financial rewards are not a primary issue for most clinicians. However, the non-financial rewards, like recognition and acknowledgement by patients, peers, and organizational leaders, are too-often lacking. Clinicians value meaningful relationships with patients, and they want connection with colleagues. The need to interact with the electronic health record makes it more difficult to create and maintain these relationships. Relationships with patients may also be less satisfying when there is less time for each patient interaction and with changing expectations from patients who are demanding testing or treatments based on a Google search rather than valuing the physician's professional judgement.

12.2.4 Breakdown of Community

Physicians value collegiality with each other. Work overload, data entry requirements, and time pressure have translated into fewer opportunities for nurses and

physicians to meet with colleagues in staff break rooms, the doctors' lounge, or over a meal. In addition, physicians and nurses interact directly less often with each other, now that physicians' orders and communication between clinicians occurs almost exclusively via computerized physician order entry (CPOE). This breakdown of community means individual clinicians may be less likely to feel a sense of support at work.

12.2.5 Absence of Fairness

Fairness is about being treated with dignity and respect regardless of one's demographics or job title. In the workplace, lack of fairness occurs when there is inconsistent handling of promotions and evaluations or when there is inequity in workload or pay (Maslach & Leiter, 2016). As the clinical workforce has increasing gender and ethnic diversity, issues of lack of fairness in hiring, promotion, and firing, are more obvious and adversely affect the work environment. Inequity can lead to burnout because experiencing lack of fairness is exhausting, and it breeds cynicism about the workplace.

12.2.6 Conflicting Values

Today, clinicians increasingly feel that the organization they work for does not share their values, such as prioritizing patient safety. In an era of administrators responding to rapid changes in the external environment, avoiding a conflict of values requires trust and regular communication from leaders to frontline clinicians. For example, organizational leaders may make policy decisions to increase access for patients, but if they fail to communicate the reasons for the resulting changes, clinicians may assume the shifts are motivated by a desire to increase profits. Also, if administrators set an aspirational target of achieving 90th percentile performance yet fail to provide the resources needed to achieve those targets, physicians see this as a conflict of values.

12.3 Aspects of the Health Care Environment That Drive Burnout

We believe that three aspects of the health care environment are especially important in the development of clinician burnout.

- Dysfunctional workflow processes
- Command and control leadership

- Unhealthy organizational culture

Dysfunctional workflow processes can manifest in lack of control and work overload. Command and control leadership can manifest in lack of control and insufficient reward. Unhealthy culture can manifest in breakdown of community, absence of fairness, and conflicting values.

First, health care is rife with dysfunctional work processes. Health care has an error rate that is thousands of times higher that of other high-risk industries, such as aviation and nuclear energy, and much less frequent use of optimal and standard processes (Kapur, Parand, Soukup, Reader, & Sevdalis, 2015; Nolan, Resar, Haraden, & Griffin, 2004). Most clinicians can describe many ways that their daily work experience involves tasks that cannot be completed efficiently, conveniently, and with a low risk of error. The "non-doable" tasks and the attendant chaos of dysfunctional work processes result in work overload.

In addition, over the last 15–20 years there have been numerous changes in the ways in which care is delivered. These changes have significantly altered the clinical workflow, often without the needed redesign to effectively incorporate them. For example, introduction of the electronic health record, without significantly changing patient care workflows from the days of paper charts, has significantly increased the data entry burden for most clinicians, and increases in prior authorization requirements have resulted in more and more physician and nurse time spent on calls to payers. An electronic monitoring study has shown that primary care physicians spend two hours on documentation for every hour of direct patient care (Sinsky et al., 2016). Not only have these changes in care delivery resulted in work overload, they have also directly affected the clinicians' ability to connect with patients (Crampton, Reis, & Shachak, 2016; Ratanawongsa et al., 2016), an essential aspect of the profession that drew them to the field in the first place.

Although electronic health records and administrative burden are often first named by physicians as causes of burnout (Gardner et al., 2019; Kane, 2019), clinical work processes were not ideal prior to the addition of these newer aspects of care delivery. However, the increased focus on cost efficiency, quality, and patient outcomes in recent years has resulted in more metrics to capture, more data to enter, and more results to analyze. Pursuing higher quality, safer care for patients has had an unintended consequence: increased clinician burnout (Spinelli, 2013). The additional work tasks and requirements associated with efforts to improve quality and safety were added onto existing tasks and requirements in most cases without careful consideration of the effect on frontline clinicians and without conscious, proactive redesign of how work is done and which team member is best suited to do each task. Physicians' time has often been viewed as expendable without additional cost to the health system, resulting in doctors' work hours expanding into the evening and weekends (Ofri, 2019).

Second, health care, as with many other industries, has been dominated by a top-down, command-and-control leadership style (de Zulueta, 2015).This approach is characterized by leadership that decides what is to be done, how to do it, and

directs the workers to perform specific tasks in specific ways to achieve outcome targets.

Such an approach is problematic when managing knowledge workers such as physicians and nurses, especially when working in dynamic and unpredictable work environments. Clinical care is often intense, carrying high stakes of life and death. Clinicians have highly specialized knowledge and skills that administrators cannot possibly know as well. When non-clinicians make decisions that impact how clinicians are able to care for their patients, it puts the patients at risk and is demoralizing for the clinicians. Examples of this include insurance company prior-authorization requirements and hospital administrators choosing diagnostic equipment.

Clinical workplaces function more effectively when clinicians with specialty expertise are engaged in the process of making decisions about the way they deliver care. While this may appear intuitively obvious, such an approach takes time and includes some risk, so administrators often find it more expedient to make decisions themselves without getting input from all key stakeholders. Examples include having physicians design exam rooms so that they can properly examine a patient as opposed to an administrator choosing a design that reduces building expenses, or allowing each clinical site to schedule a daily huddle when it works best for the staff at that location rather than having the director dictate that all huddles happen at the same time for the convenience of the director.

Third, the organizational and professional culture in which health care is delivered is often unhealthy for workers. Organizational culture, which can be defined as "shared and fundamental beliefs of a group that are so widely accepted that they are implicit and often no longer recognized" (Shanafelt, Schein, et al., 2019) can create, condone, or exacerbate drivers of burnout. Specifically, in an organization where the spoken or unspoken demand for specific performance outcomes is extremely strong, leaders and middle managers will generally focus on the performance of frontline clinicians and push them toward specific outcomes without a concomitant effort to redesign workplaces and work processes that support the delivery of high-quality, safe, clinical care. The focus on performance outcomes at the expense of workplace functioning creates an environment where the accepted norm is "not doable work" for frontline clinicians. In addition, the focus on performance without creating the conditions in which to succeed is a missed opportunity to engage workers and achieve positive outcomes.

Clinicians also operate with a professional culture that includes unhealthy aspects. As one report describes, "Too often, new care providers enter a system in which disrespect for one's peers and coworkers is not only tolerated, it is the norm" (Institute for Healthcare Improvement, 2013). Historically, medical training has emphasized sacrifice, delayed gratification of needs, lack of self-care, independence, not asking for help, and ignoring basic human needs such as sleep. This culture is changing somewhat as millennials enter the clinical workforce in increasing numbers (Frelick, 2019), but aspects of the unhealthy professional culture remain. New nurses entering the workforce struggle for a variety of reasons (Hofler & Thomas, 2016). In their clinical training the workloads are significantly lower than they are

expected to manage once they are on the wards, resulting in them feeling overwhelmed as they begin their first nursing jobs. The nursing shortage has left their assigned mentors overburdened, resulting in inadequate orientation and exposure to mentors who are burned out themselves. Twelve-hour shifts, once thought to be a benefit to reduce stress by providing 4 days off a week, have been shown to increase stress and error rates (Stimpfel & Aiken, 2013; Stimpfel, Sloane, & Aiken, 2012).

Ultimately, unhealthy organizational and professional culture adversely affects several drivers of professional burnout, including community, work overload, lack of fairness, and conflicting values.

12.4 Envisioning the Optimal Clinical Workplace

What would an optimal (i.e., functional, non-toxic) clinical workplace look like? By definition, it would be a work setting that negates or minimizes the six drivers of professional burnout and the three aspects of the health care environment that we believe are especially important in the development of clinician burnout. In building the optimal clinical workplace, however, organizational leaders would do well to aim beyond a goal of reducing burnout to the goal of enabling clinicians to thrive in their work.

Here, we consider, as a model for enabling clinicians to thrive, the three components of motivation of the general workforce identified in *Drive: The Surprising Truth About What Motivates Us* by Daniel Pink: autonomy, mastery, and purpose (Pink, 2009). Pink's research was not focused on health care workers, but we believe it is especially applicable because the values of autonomy, mastery, and purpose are deeply ingrained in providing quality patient care (Kane, 2019; Rizk, 2018).

Autonomy is important to all clinicians, especially physicians, whose training often focuses on the ability to make independent decisions and to own the ultimate responsibility for patient outcomes. Enabling autonomy does not mean avoidance of teamwork or eschewing best practices or standardized protocols. Instead, it means that clinicians have the leeway and resources and feel empowered to fix local problems and escalate those they cannot fix themselves. Empowering physicians to fix frustrations at the local level (or “pebbles in your shoe”) fosters autonomy in designing the way that care is delivered in the clinical workplace. An example of autonomy in the clinical setting is the ability to vary scheduling and staffing for local needs. Autonomy in this context does not mean that clinicians have complete control to select clinical treatment options that do not align with widely accepted community standards of care.

For clinicians, *mastery* includes direct clinical abilities, such as diagnostic and treatment skills, and other competencies, such as communication and leadership skills. In the past, clinician training has primarily focused on direct clinical competencies, often leaving clinicians underprepared for engaging in ideal communication,

team building, leadership, and self-care. These competencies can be addressed through specific training and modeling by leaders.

Finally, *purpose* is all-important to clinicians both individually and collectively. Most health care professionals enter the field because of a desire to be of service to others and reduce suffering. Engaging clinicians in creating shared mission, vision, and values can help to ensure a shared understanding of purpose. However, few physicians think mission, vision, and values statements are important, as evidenced in blog postings by physicians. In many institutions, the disconnect between the C-level leaders and clinicians on the front lines of care leads to distrust and cynicism, which is exacerbated when clinicians see examples of organizations violating their stated values.

As hospital systems and medical groups grow through acquisition, it is increasingly important to ensure that merging entities do actually share core values. This can be made more meaningful by developing a compact—a document that explains how both parties (individuals and the organization) will reciprocally honor each value. For example, if “quality” is a value, physicians will commit to closing care gaps in each encounter, and the organization will commit to providing them the resources needed to do so effectively.

A healthy clinical workplace is one in which clinicians can spend most of their time in direct patient care because the burdens associated with data entry and other administrative requirements are minimized. Such practices provide support to clinicians by hiring additional staff to perform data entry and administrative tasks. For example, the department of Family Medicine at the University of Colorado Health System instituted a team-based model in which medical assistants complete a structured process with patients at the beginning of the visit, remain in the room to perform documentation, and provide patient education and health coaching, allowing the physician to focus on medical decision making (Wright & Katz, 2018). It is also an environment that promotes psychological and physical safety, as well as a strong sense of community. This benefits clinicians by allowing them to do their work efficiently and by reducing the underlying drivers of burnout. It also benefits patients, through more satisfying interactions with their clinicians, easier navigation of a clinical environment, and lower rates of medical error. Physicians can see more patients and be more fulfilled if they spend their time connecting to patients rather than documenting the time spent with patients. The good news for health care organizations is that achieving an optimal clinical workplace is possible while improving the most important organizational performance measures, including financial metrics, reputation in the marketplace, and customer (patient) loyalty.

12.5 Moving from the Vision to Execution

Worldwide, efforts are growing to reduce burnout and improve clinician well-being. However, little research has been conducted to date regarding the effects of leadership style on clinician burnout. The lack of existing evidence must be remedied with ongoing research but should not impede steps toward improvement, when guided by expert opinion and best practices.

The Stanford Model for professional fulfillment categorizes interventions into three domains: personal resilience, efficiency of practice, and culture of wellness (Bohman et al., 2017). Much effort has gone into enhancing personal resilience to help individuals cope with the dysfunctional workplace, but these interventions do not address the root causes of burnout.

Organizational leaders are increasingly focusing on improving efficiency of practice by redesigning dysfunctional workflows and eliminating non-clinical tasks or assigning them to support staff, allowing clinicians to better focus on the patient. Leaders must engage and empower the frontline clinicians and non-clinical staff to effectively identify and fix these workflows, because these individuals are best situated to know what is broken and how to fix it.

Engaging and empowering clinicians is critical for improving the culture of wellness. Senior leadership must commit to transforming the management system and organizational culture. In this section, we will describe the key components necessary for such a transformation: servant leadership style, organizational structure that supports mentoring, and a daily management system that empowers the frontline and facilitates efficient, cross-organization communication.

12.5.1 Servant Leadership

Creating a healthy, functional workplace requires a shift from a top-down, command-and-control style of leading to servant leadership. While servant leadership is rare in practice (Aij & Rapsaniotis, 2017; Pfeffer, 2018; Trastek, Hamilton, & Niles, 2014), its features are widely described in business books (Chapman & Sisodia, 2015; Schein & Schein, 2018; Suchman, Sluyter, & Williamson, 2018).

This style of leading is characterized by mutual respect and by mentoring not managing ("mentor people to manage processes"). It results in workers that are empowered and aware of and aligned with larger organizational goals. As a result, the organization achieves better performance on a variety of metrics, including financial, quality, safety, customer service, patient engagement, access to services, and employee engagement.

Servant leadership is not passive. It is a proactive, hands-on approach that often requires personal change for those in top leadership positions. If a leader actively engages in servant leadership, middle managers will view this change as important

and adopt a similar style. If top leadership does not actively engage, middle managers who are not inclined to change will not transform.

For most top leaders, who were educated in command-and-control leadership, shifting from a commander to a mentor role requires guidance and support from an executive coach. Leaving the known for the new is challenging for everyone, including leaders who have held the belief that mandating and dictating equate to strong leadership and whose identity has been tied to solo decision-making.

Servant leadership is also effective for health care professionals who are not in executive C-suite positions. Managers and frontline clinicians can pursue change within their specific sphere of influence by applying these principles to areas over which they have control. After securing approval from superiors, they can try a pilot project in a service line or clinical unit. After making small tests of change they can seek opportunities to share best practices with other clinical units.

To maximize the benefits of a servant leadership style, leaders need two key elements: an organizational structure that enables and encourages mentoring rather than managing and a management system that empowers front-line problem solving.

12.5.2 Organizational Structure That Supports Mentoring

The ideal organizational structure for servant leadership supports mentoring and creates the framework for an effective daily management system. This structure clarifies which individuals are responsible for each role and task. It can be described as an "inverted org chart," in that the focus is on supporting and empowering the frontline workers who provide the actual value delivered to customers (i.e., clinicians providing patients with health care services). The manager's role is to support the frontline worker, and upper management's role is to support both managers and frontline workers.

This organizational structure addresses demand and capacity issues for each role, through the use of strategy deployment, which is a process for assigning responsibility to implement strategic and performance improvement initiatives. This is developed in a process of "catchball" in which those assigning tasks and those accepting the task agree that the expectations are achievable, providing the opportunity for workers, managers, and leaders to be successful. (For more information, see the resource list at the end of the chapter.) Simply rearranging roles on paper is insufficient, however; the ideal structure requires redesign of work processes and the removal of some tasks ("de-selecting") when new ones are added (Fig. 12.1).

In contrast with the traditional organizational chart, the inverted org chart places the front line worker at the top of the chart, and each successive layer of management below the next layer, indicating that upper and middle management *support* those who report to them.

Leaders who engage in personal transformation, which requires openness to change and coaching, will be most successful. This organizational structure and coaching enable the personal changes that every individual at each level of the

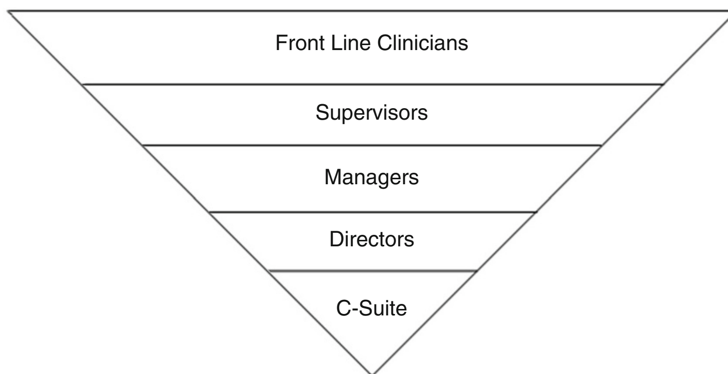

Fig. 12.1 Inverted organizational chart

organization must adopt for the clinical workplace to become functional and optimized. Similarly, organizations that undergo culture change will be more effective at creating optimal workplaces (Pourbarkhordari, Zhou, & Pourkarimi, 2016; Troy, 2008).

12.5.3 Management System That Empowers Front-Line Problem Solving

Several authors have provided the theoretical basis for leadership that empowers frontline workers (Pfeffer, 2018; Pink, 2009). However, they have not provided specific details on a management process that would support and enable such empowerment. We believe an essential component of an effective management process is a daily management system with tiered, structured huddles with visual management for team communication, such as white boards in each clinical unit that show current performance and planned work for the day (Ulhassan, von Thiele Schwarz, Westerlund, Sandahl, & Thor, 2015).

These huddles have a different focus at each level of the organization. At the frontlines, huddles focus on daily needs to provide care. Key components of such huddles include:

- Preparing for the day—identifying any potential supply-demand mismatch (based on the schedule or census, assessing whether there are enough staff, the supplies are sufficient, and the equipment needed is functioning properly)
- Identifying and developing a plan to fix small problems that happened the previous day (“pebbles in your shoe”), to prevent them from recurring
- Tracking metrics at the local level that are aligned with the organization’s targets
- Acknowledging team members for special effort or notable life events (birthdays, children’s achievements, etc.)

At the manager and leader levels, huddles focus on assessing resources and demands and removing barriers escalating issues that were raised at the frontline huddles which cannot be resolved with the resources or authority of the frontlines workers.

Effective management processes have numerous benefits for leaders, including reduced time spent in meetings and responding to inbound communications, more time to strategize rather than put out fires and to visit the clinical workplace and observe gaps and successes firsthand. When such huddles are tiered up to the C-suite, the CEO has much greater awareness of any operational challenges early on and is rarely surprised by a problem not being resolved. (To learn more about management processes that enable empowered frontline workers, see the resource list at the end of the chapter.)

An effective daily management system, along with servant leadership and an organizational structure that supports mentoring, creates an organization that is more resilient and can respond more rapidly and effectively to changes in the external environment, such as strategic threats, technology advances, or new regulatory requirements.

12.6 Connecting the Dots: Leadership Style and Clinician Well-Being

Leadership style has a direct impact on clinician well-being. Researchers at the Mayo Clinic have shown that negative leadership behaviors directly correlate with the risk of burnout among physicians supervised by that leader. These behaviors include failure to hold career development conversations, not treating the physician with dignity and respect, and failure to keep the physician informed about changes taking place in the organization (Shanafelt et al., 2015). Leaders who lead by mentoring resist providing solutions to problems, but instead support the clinical teams—the individuals who best know the nature of the problems at the locus of care delivery—to develop solutions. Mentoring empowers and engages. The personal experience of one of us (P.D.) as CEO of the Sutter Gould Medical Foundation demonstrated that this style of leadership mitigates the six drivers of clinician burnout:

- Teams are able to redesign work processes to remove waste and reduce *work overload.*
- Clinicians experience greater autonomy, are empowered to make local changes to improve work efficiency, care quality, and patient safety, addressing *lack of control.*
- Clinical teams show greater appreciation for each other, which is one component of addressing *insufficient reward.*
- Clinical teams working together to redesign workflows and solve local problems experience collaboration, counteracting *breakdown of community.*

- The collaboration that ensues when clinical teams work to identify and address local problems increases their understanding of others' perspective and priorities, thus improving mutual respect among team members and reducing the sense of *absence of fairness*.
- When teams are aligned around improving performance on frontline metrics that align to the organization's strategy and goals, and the C-level leaders are communicating these to the frontlines, the risk of *conflicting values* decreases significantly.

Servant leadership and the associated culture change not only reduce the drivers of clinician burnout, but also result in several other positive outcomes that are important to health care organizations, leaders, clinicians, patients, and society. First, it has been our experience that by reducing burnout, servant leadership can reduce its negative downstream effects, including lack of engagement, medical errors, lower patient satisfaction, high staff turnover, and inadequate billing (lower reimbursement due to lower performance-based compensation and lower productivity in clinicians with burnout). Second, servant leadership can reduce waste and delays. It is estimated that one third of health care in the US represents waste (Institute of Medicine, 2013; Lalleman, 2012). By proactively engaging the front line as problem-solvers, servant leadership can reduce costs by eliminating wasted time, goods, and services.

Third, servant leadership is better suited for the current health care arena. Frontline clinicians are knowledge workers with specific training and skill sets that managers often do not have. In this world, it is ineffective for managers and leaders to expect improved performance without collaborating with clinicians and providing the needed support, resources, and work environment.

Finally, servant leadership enables the health care organization to be more adaptable to changes in the external environment, such as new patient safety challenges, changes in technology, changes in financing, and greater awareness of equity and access issues. By mentoring managers rather than dictating mandates to them, by opening communication channels with frontline clinicians, by fostering problem solving by those most closely involved in care delivery, servant leadership helps create an organization better poised to make rapid adjustments to external stressors.

12.7 Challenges to Spreading Servant Leadership

Over the past few decades, many leadership experts, including Simon Sinek, Bob Chapman, and Jeffrey Pfeffer have recommended a servant leadership style, or one with similar attributes. However, servant leadership is the exception and not the rule (Stoller, 2015). If this style of leading has been identified by experts as advantageous, why aren't more organizations adopting it, especially in the for-profit sector

where there is tremendous pressure from shareholders to improve financial performance?

Shifting from the traditional, command and control style of leadership to servant leadership is challenging for a host of reasons. First, any change invokes fear and resistance, because it involves moving from the status quo. Fear of change is personal; people worry about the potential effects on their career and livelihood (Maurer, 2010). Adopting a new and unfamiliar style of leadership requires internal change within the leader. Seeing the benefits of change generally takes time—the shift must build momentum, which is not instantaneous.

Second, for a variety of reasons, health care as an industry is conservative and risk averse. The service provided involves life and death. Health care operates in a VUCA environment (volatility, uncertainty, complexity, and ambiguity) making any change more risky. There are valid concerns about maintaining viable financial margins, which are significantly narrower for most health care organizations than in other industries, making the stakes associated with a misstep greater. Given the significant challenges of attempting to fix the current work processes, reduce waste, and increase the efficiency of operations, many leaders opt to prioritize instead mergers and acquisitions, which increase market power and expand sources of revenue, mitigating the need for organizational change.

Third, senior leaders often have business expertise but are not well-versed in frontline clinical issues. They are focused on "running a business" and may not consider mentoring or closely communicating with clinicians to be part of their realm. In addition, many senior leaders trained in top-down management have achieved their status through traditional leadership behaviors and have bought into the hierarchy inherent in most health care organizations. Their personal success has been achieved using top-down management, so they question the need to change.

Leaders adopting servant style leadership accept that everyone in the organization may have information to share that can improve service delivery, cost, efficiency, and other key performance metrics. Top leaders are ready to listen to new ideas and potential solutions, whether they originate in the C-suite, among middle managers, frontline clinicians, or housekeeping or other support staff.

12.8 Taking Action: Adopting Servant Leadership and Creating Optimal Clinical Workplaces

When a leader accepts the theory that problems with performance should be addressed with workplace redesign and empowering the frontline to identify and solve problems, he or she may find it challenging to execute on this theory in the current market, where there is overwhelming pressure to demonstrate improvement in performance outcomes in the short term. Having the support of the board of directors is essential. If the board members are able to focus on long-term success, rather than the next quarter, they are more likely to support decisions that

drive sustainable improvements, including investing in the changes needed to redesign the workplace.

Culture and leadership style can change more quickly when higher level leaders are engaged. A single leader cannot achieve these changes alone. Instead, leaders across the organization must be engaged in order to inculcate the organization with the new version of "how we do things here." To read about organizations that have adopted a coaching and mentoring style of leadership, see the case studies in the resource list at the end of the chapter.

12.9 Conclusion

Clinician burnout is a widespread problem caused by toxic, dysfunctional clinical workplaces. Clinicians are adversely affected, as are patients, leaders, private and public payers, and society overall. Optimal clinical workplaces are designed to ensure clinicians can connect compassionately with their patients, and effectively and efficiently care for them.

Creating optimal workplaces will require both individual and organizational change. Individual leaders must shift from command-and-control leadership to mentoring. Managers must shift from managing people to managing the process. Clinicians must participate in change processes and engage in identifying and fixing workflow problems. Organizations must invest in leadership development, adopt an inverted org chart, enable and support servant leadership, and implement strategy deployment, process improvement, and an effective daily management system.

Toxic workplaces are a significant driver of clinician burnout. Now is the time for health care leaders to transform themselves and their organizational cultures to create optimal clinical workplaces. A leader who embraces a servant leadership style, engages with and empowers frontline staff, and prioritizes clinician well-being can create a healthier clinical workplace, ultimately benefiting clinicians, patients, and the organization, as well as realizing greater personal and professional fulfillment themselves.

Key messages for researchers
More study is needed to identify the most effective approaches to improving the clinical workplace, such as management systems, workplace culture, leadership attributes, and workflow redesign opportunities. – Determine optimal metrics to better assess individual thriving, clinician wellbeing, effective teams, and reducing hassle factors – Develop more effective approaches to measuring the cost of burnout beyond turnover, and the return on investment of burnout reduction interventions – Identify root causes that hold leaders back from fully engaging in burnout reduction work and effective interventions to drive leaders to engage more fully
A strong body of literature exists regarding servant leadership in other industries. More research on servant leadership in healthcare would be beneficial. – Develop case studies on servant leadership in health care to provide examples other leaders can emulate

(continued)

– Identify outcomes associated with servant leadership in health care – Identify features or capabilities of leaders best exemplify servant leadership in health care – Identify best practices for how these competencies can be learned – Recommend changes to masters in business administration (MBA) and Health Care Administration (HCA) programs to reinforce servant leadership
Key messages for health care delivery
Health care organizations should: – Invest significantly more resources in designing practice workflows to enhance efficiency, with the potential for substantial improvement in all performance metrics – Focus more attention on improving their management system and culture of wellness, and expanding these efforts organization-wide rather than only at the local units or departments level – Implement an organization-wide daily management system that aligns and empowers frontline clinicians – Consider a hybrid or pilot approach for leadership change: select a part of the organization (i.e., "a model cell") to shift into a mentoring style of leadership; demonstrated improvement in the model cell can help engage the rest of the organization – Seek out opportunities to observe organizations that have made changes in leadership style and culture, through study trips and site visits – Connect with other organizations pursuing optimal workplaces. For example, consider joining the Health Care Value Network or the Association for Manufacturing Excellence. – Review the literature on change management. (See the resources list at the end of the chapter.)
Executive leaders should: – Shadow clinicians to learn firsthand about the challenges they face – Prioritize efforts to design workflows that provide clinicians more time to directly engage with patients and less time engaged with administrative work. These design efforts should be led by clinicians with administrative support – Focus more intensively on improving organizational culture away from traditional "command and control" and towards servant leadership, recognizing the challenges described in this chapter – Engage an executive coach to help guide the shift, unless leaders have led successful organizational culture change in the past. One key advantage of external coaches in this setting is that they do not have management responsibility in the organization and can be considered a safe confidant with whom a senior leader can express concerns
Boards of Directors should: – Include and prioritize clinician well-being as a key performance indicator – Shadow clinicians to learn firsthand about the challenges they face

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